

C Medicare B CONNECTION

medicare.fcso.com



A Newsletter for MAC Jurisdiction N Providers

March 2020



In this issue

New Medicare Beneficiary Identifier (MBI) Get it, Use it.....	5
Revised rates for opioid treatment programs (OTPs)....	8
Sacroiliac joint injection -- revision to Part B billing and coding article	10
Multiple Part B LCDs being retired	13

MLN Connects® – Special Edition for March 13, 2020

COVID-19: Test Pricing, Diagnostic Lab Tests, Pricing & Codes, and EHB Coverage

- [COVID-19: Test Pricing; Diagnostic Lab Tests, Pricing & Codes; and EHB Coverage](#)
- [Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment MLN Matters® Article](#)
- [Essential Health Benefits \(EHB\) Coverage](#)

COVID-19: Test Pricing; Diagnostic Lab Tests, Pricing & Codes; and EHB Coverage

On March 12, CMS posted a [fact sheet](#) with information relating to the pricing of both the Centers for Disease Control and Prevention (CDC) and non-CDC tests.

Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment MLN Matters® Article

A new MLN Matters Article MM 11681 on [Quarterly Update for Clinical Laboratory Fee Schedule and Laboratory Services Subject to Reasonable Charge Payment](#) is available. Learn about Advanced Diagnostic Laboratory

Tests, pricing, and new codes. On page 3, we reference new COVID-19 codes.

Essential Health Benefits (EHB) Coverage

On March 12, CMS issued [Frequently Asked Questions \(FAQs\)](#) about EHB to ensure individuals, issuers, and states have clear information on coverage benefits for COVID-19. This action is part of the broader, ongoing effort by the White House Coronavirus Task Force to ensure that all Americans – particularly those at high-risk of complications from the COVID-19 virus – have access to the health benefits that can help keep them healthy while helping to contain the spread of this disease.

These FAQs, and earlier CMS actions in response to the COVID-19 virus, are part of the ongoing White House Task Force efforts. To keep up with the important work the Task Force is doing in response to COVID-19; visit the CDC's [Coronavirus Disease 2019](#) webpage.

For information specific to CMS, please visit the [Current Emergencies](#) website.

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).



WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Medicare B Connection

MLN Connects® – Special Edition for March 13, 2020 1

About the Medicare B Connection

About the *Medicare B Connection* 3

Advance beneficiary notices 4

General Information

New Medicare Beneficiary Identifier (MBI) Get it, Use it 5

MSI reminder announcement: There is still time to evaluate our services! 7

Claims

OTPs

Revised rates for opioid treatment programs (OTPs) 8

Local Coverage Determinations

Looking for LCDs? 9

Advance beneficiary notice 9

Revised LCDs/Articles

Vascular endothelial growth factor inhibitors for the treatment of ophthalmological diseases -- revision to the Part A and Part B billing and coding article 10

Sacroiliac joint injection -- revision to Part B billing and coding article 10

Major joint replacement (hip and knee) -- revision to the Part A and Part B billing and coding article 10

BRCA1 and BRCA2 genetic testing -- revision to the Part A and Part B billing and coding article 11

Trastuzumab - trastuzumab biologics -- revision to the Part A and Part B Billing and Coding Article 11

Peripheral nerve blocks -- revision to Part B billing and coding article 11

Pegfilgrastim -- revision to the Part A and Part B local coverage determination and billing and coding article 12

Stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) – revision to the Part A and Part B local coverage determination and billing and coding article 12

Revision to the Part A and Part B Billing and Coding Article A57077 12

Revision to the Part A and Part B billing and coding article A57778 13

Revision to the Part A and Part B article A52571 13

Retired LCDs/Articles

Multiple Part B LCDs being retired 13

Educational Resources

Upcoming provider outreach and educational events 14

CMS MLN Connects®

MLN Connects® for February 20, 2020 15

MLN Connects® for February 27, 2020 16

MLN Connects® Special Edition for March 4, 2020 16

MLN Connects® for March 5, 2020 18

MLN Connects® Special Edition for March 6, 2020 18

MLN Connects® Special Edition for March 9, 2020 20

MLN Connects® for March 12, 2020 21

Contact Information

Florida Contact Information 22

U.S. Virgin Islands Contact Information 23

Puerto Rico Contact Information 24

Order Form

Medicare Part B materials 25

The *Medicare B Connection* is published monthly by First Coast Service Options Inc.'s Provider Outreach & Education division to provide timely and useful information to Medicare Part B providers.

Articles included in the *Medicare B Connection* represent formal notice of coverage policies. Policies have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined within to ensure compliance with Medicare coverage and payment guidelines.

CPT® five-digit codes, descriptions, and other data only are copyright 2018 by American Medical Association (or such other date of publication of CPT®). All Rights Reserved. Applicable FARS/DFARS apply. No fee schedules, basic units, relative values or related listings are included in CPT®. AMA does not directly or indirectly practice medicine or dispense medical services. AMA assumes no liability for data contained or not contained herein.

ICD-10-CM codes and its descriptions used in this publication are copyright 2019 Optum360, LLC. All rights reserved.

This document contains references to sites operated by third parties. Such references are provided for your convenience only. Florida Blue and/or First Coast Service Options Inc. do not control such sites and are not responsible for their content. The inclusion of these references within this document does not suggest any endorsement of the material on such sites or any association with their operators.

All stock photos used are obtained courtesy of a contract with www.shutterstock.com.

About the Medicare B Connection

The *Medicare B Connection* is a comprehensive publication developed by First Coast Service Options Inc. (First Coast) for Part B providers in Florida, Puerto Rico, and the U.S. Virgin Islands and is distributed on a monthly basis.

Important notifications that require communication in between publications will be posted to the First Coast Medicare [provider education website](#). In some cases, additional unscheduled special issues may be posted.

Who receives the *Connection*

Anyone may view, print, or download the *Connection* from our provider education website(s). Providers who cannot obtain the *Connection* from the internet are required to register with us to receive a complimentary hardcopy.

Distribution of the *Connection* in hardcopy is limited to providers who have billed at least one Part B claim to First Coast Medicare during the twelve months prior to the release of each issue. Providers meeting these criteria are eligible to receive a complimentary copy of that issue, if a technical barrier exists that prevents them from obtaining it from the internet and they have returned a completed registration form to us.

Registration forms must be submitted annually or when you experience a change in circumstances that impacts your electronic access.

For additional copies, providers may purchase a separate annual subscription (see order form in the back of this issue). All issues published since 1997 may be downloaded from the internet, free of charge.

We use the same mailing address for all correspondence, and cannot designate that the *Connection* be sent to a specific person/department within a provider's office. To ensure continued receipt of all Medicare correspondence, providers must keep their addresses current with the Medicare provider enrollment department. Please remember that address changes must be done using the appropriate CMS-855.

Publication format

The *Connection* is arranged into distinct sections.

- The **Claims** section provides claim submission requirements and tips.
- The **Coverage/Reimbursement** section discusses specific CPT® and HCPCS procedure codes. It is arranged by categories (not specialties). For example,



“Mental Health” would present coverage information of interest to psychiatrists, clinical psychologists and clinical social workers, rather than listing articles separately under individual provider specialties. Also presented in this section are changes to the Medicare physician fee schedule, and other pricing issues.

- The section pertaining to **Electronic Data Interchange (EDI)** submission also includes information pertaining to the Health Insurance Portability and Accountability Act (HIPAA).
- The **Local Coverage Determination** section features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives.
- The **General Information** section includes fraud and abuse, and national provider identifier topics, plus additional topics not included elsewhere.
- In addition to the above, other sections include:
 - **Educational Resources**, and
 - **Contact information** for Florida, Puerto Rico, and the U.S. Virgin Islands.

The *Medicare B Connection* represents formal notice of coverage policies

Articles included in each edition represent formal notice that specific coverage policies either have or will take effect on the date given. Providers are expected to read, understand, and abide by the policies outlined in this document to ensure compliance with Medicare coverage and payment guidelines.

Never miss an appeals deadline again

When it comes to submitting a claims appeal request, *timing is everything*. Don't worry – you won't need a desk calendar to count the days to your submission deadline. Try our “*time limit*” calculators on our [Appeals of claim decisions page](#). Each calculator will *automatically calculate* when you must submit your request based upon the date of either the initial claim determination or the preceding appeal level.

Medicare Part B advance beneficiary notices

Medicare Part B allows coverage for services and items deemed medically reasonable and necessary for treatment and diagnosis of the patient.

For some services, to ensure that payment is made only for medically necessary services or items, coverage may be limited based on one or more of the following factors (this list is not inclusive):

- Coverage for a service or item may be allowed only for specific diagnoses/conditions. Always code to the highest level of specificity.
- Coverage for a service or item may be allowed only when documentation supports the medical need for the service or item.
- Coverage for a service or item may be allowed only when its frequency is within the accepted standards of medical practice (i.e., a specified number of services in a specified timeframe for which the service may be covered).

If the provider believes that the service or item may not be covered as medically reasonable and necessary, the patient must be given an acceptable advance notice of Medicare's possible denial of payment if the provider does not want to accept financial responsibility for the service or item. Advance beneficiary notices (ABNs) advise beneficiaries, before items or services actually are furnished, when Medicare is likely to deny payment.

Patient liability notice

The Centers for Medicare & Medicaid Services' (CMS) has developed the Advance Beneficiary Notice of Noncoverage (ABN) (Form CMS-R-131), formerly the "Advance Beneficiary Notice." Section 50 of the *Medicare Claims Processing Manual* provides instructions regarding the notice that these providers issue to beneficiaries in advance of initiating, reducing, or terminating what they

believe to be noncovered items or services. The ABN must meet all of the standards found in Chapter 30. Beginning March 1, 2009, the ABN-G and ABN-L was no longer valid; and notifiers must use the revised Advance Beneficiary Notice of Noncoverage (CMS-R-131). [Section 50 of the Medicare Claims Processing Manual](#).

Reproducible copies of Form CMS-R-131 ABNs (in English and Spanish) and other BNI information may be found [here](#).

ABN modifiers

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting modifier GA (waiver of liability statement on file) or GZ (item or service expected to be denied as not reasonable and necessary) with the service or item.

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Modifier GZ may be used in cases where a signed ABN is not obtained from the patient; however, when modifier GZ is billed, the provider assumes financial responsibility if the service or item is denied.

Note: Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.



GA modifier and appeals

When a patient is notified in advance that a service or item may be denied as not medically necessary, the provider must annotate this information on the claim (for both paper and electronic claims) by reporting the modifier GA (waiver of liability statement on file).

Failure to report modifier GA in cases where an appropriate advance notice was given to the patient may result in the provider having to assume financial responsibility for the denied service or item.

Nonassigned claims containing the modifier GA in which the patient has been found liable must have the patient's written consent for an appeal. Refer to the applicable contact section located at the end of this publication for the address in which to send written appeals requests.

New Medicare Beneficiary Identifier (MBI) Get it, Use it

Note: We revised the article on March 19, 2020, to clarify that you need the beneficiary's first name, last name, date of birth, and SSN to use MBI look-up tool. All other information remains the same.

This information was previously published in the *January 2020 Medicare B Connection*, pages 7-9.

Provider type affected

This Special Edition MLN Matters® Article is for physicians, providers, and suppliers submitting claims to Medicare Administrative Contractors (MACs), including Durable Medical Equipment MACs (DME MACs) and Home Health and Hospice MACs, for services provided to Medicare beneficiaries.

Provider action needed

Use MBIs for all Medicare transactions.

The Centers for Medicare & Medicaid Services (CMS) replaced the Social Security Number (SSN)-based Health Insurance Claim Numbers (HICNs) with the MBI and mailed new Medicare cards to all Medicare beneficiaries.

The cards with MBIs offer better identity protection.

With a few exceptions, Medicare will reject claims you submit with Health Insurance Claim Numbers (HICNs). Medicare will reject all eligibility transactions you submit with HICNs.

There are 3 ways you and your office staff can get MBIs:

1. Ask your Medicare patients

Ask your Medicare patients for their new Medicare cards when they come for care. If they don't bring it with them when they come for care, give them the Get Your New Medicare Card flyer in [English](#) or [Spanish](#).

2. Use the MAC's secure MBI look-up tool

You can look up MBIs for your Medicare patients when they don't or can't give them. [Sign up](#) for the Portal to use the tool.

Even if your patients are in a Medicare Advantage Plan, you can look up their MBIs to bill for things like indirect medical education.

You must have your patient's first name, last name, date of birth and Social Security Number (SSN) to search.

The SSN may differ from the HICN, which uses the SSN of the primary wage earner. If your Medicare patient doesn't want to give the SSN, tell your patient to log into [mymedicare.gov](#) to get the MBI.

If the look-up tool returns a last name matching error and the beneficiary's last name includes a suffix, such as Jr. Sr. or III, try searching without and with the suffix as part of the last name.

You won't get an MBI from the look-up tool if the beneficiary has a date of death greater than 13 months from the date of your search. Instead, we return the date of death. This aligns with timely filing for a claim.

3. Check the remittance advice

If you previously saw a patient and got a claim payment decision based on a claim submission with a HICN before January 1, 2020, look at that remittance advice. We returned the MBI on every remittance advice when a provider submitted a claim with a valid and active HICN from October 1, 2018 through December 31, 2019.

Background

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) required CMS to remove SSNs from all Medicare cards. CMS replaced the SSN-based HICN with a new, randomly generated MBI.

The new MBI hyphens on the card are for illustration purposes: don't include the hyphens or spaces on transactions.

The MBI uses numbers 0-9 and all uppercase letters except for S, L, O, I, B, and Z. We exclude these letters to avoid confusion when differentiating some letters and numbers (**for example, between "0" and "O"**). Review the [MBI specifications format](#).



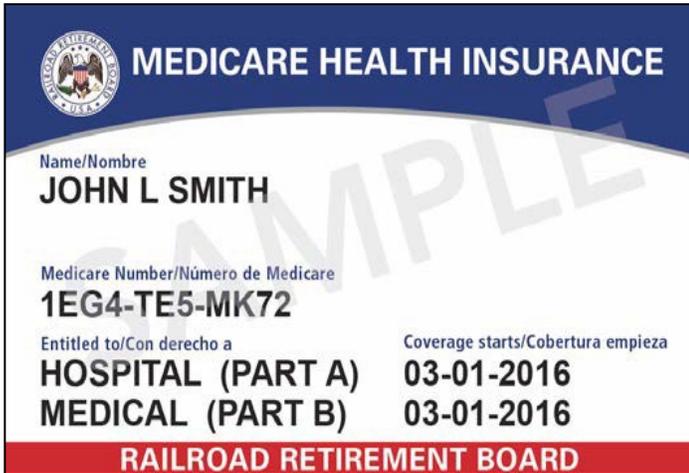
The Railroad Retirement Board (RRB) also mailed Medicare cards with MBIs. There is a RRB logo in the upper left corner and "Railroad Retirement Board" at the bottom, but you can't tell from looking at the MBI if your patient is eligible for Medicare because they're a railroad retiree.

You can identify them by the RRB logo on their card, and we return a "Railroad Retirement Medicare Beneficiary" message on the Fee-For-Service (FFS) MBI eligibility transaction response.

See **MBI**, page 6

MBI from page 5

RRB issued Medicare card



Use the MBI the same way you used the HICN. This also applies to reporting informational only and no-pay claims. **Don't use hyphens or spaces with the MBI to avoid rejection of your claim.** Use the MBI on Medicare transactions including Billing, Eligibility Status, and Claim Status. The effective date of the MBI is the date each beneficiary was or is eligible for Medicare. If you don't use the MBI, we will reject claims, with few exceptions. You will get:

- Electronic claims- Reject codes: Claims Status Category Code of A7 (acknowledgment rejected for invalid information), a Claims Status Code of 164 (entity's contract/member number), and an Entity Code of IL (subscriber)
- Paper claims- paper notice; Claim Adjustment Reason Code (CARC) 16 "Claim/service lacks information or has submission/billing error(s)" and Remittance Advice Remark Code (RARC) N382 "Missing/incomplete/invalid patient identifier"

The beneficiary or their authorized representative can request an MBI change. CMS can also change an MBI. An example is if the MBI is compromised. It's possible for your patient to seek care before getting a new card with the new MBI:

If you get a HETS eligibility transaction error code (AAA 72) of "invalid member ID," your patient's MBI may have changed. There are different scenarios for using the old or new MBIs:

FFS claims submissions with:

- Dates of service before the MBI change date – use old or new MBIs.
- Span-date claims with a "From Date" before the MBI change date – use old or new MBIs.
- Dates of service that are entirely on or after the effective date of the MBI change – use new MBIs

FFS eligibility transactions when the:

- Inquiry uses new MBI – we'll return all eligibility data.
- Inquiry uses the old MBI and request date or date range overlap the active period for the old MBI – we'll return all eligibility data. We'll also return the old MBI termination date.
- Inquiry uses the old MBI and request date or date range are entirely on or after the effective date of the new MBI – we'll return an error code (AAA 72) of "invalid member ID."

When the MBI changes, we ask the beneficiary to share the new MBI with you. You can also get the MBI from your MAC's secure MBI lookup tool.

Exceptions

You **MUST** submit claims using MBIs, no matter what date you performed the service, with a few exceptions:

- Appeals – You can use either HICNs or MBIs for claim appeals and related forms.
- Claim status query – You can use the HICN or MBI to check the status of a claim (276 transactions) if the earliest date of service on the claim is before January 1, 2020. If you are checking the status of a claim with a date of service on or after January 1, 2020, you must use the MBI.
- Span-date claims – You can use HICNs or MBIs for 11X-Inpatient Hospital, 32X- Home Health (home health final claims and Request for Anticipated Payments [RAPs]) and 41X-Religious Non-Medical Health Care Institution claims if the "From Date" is before the end of the transition period (December 31, 2019). If a patient starts getting services in an inpatient hospital, home health, or religious non-medical health care institution before December 31, 2019, you may submit a claim using either the HICN or the MBI, even if you submit it after December 31, 2019.

Medicare crossover claims

Medicare's Coordination of Benefits Agreement (COBA) trading partners (supplemental insurers, Medigap plans, Medicaid, etc.) must submit the MBI to get Medicare crossover claims. *Exceptions* on use of HICN on outbound Medicare crossover claims will apply.

Remember:

The MBI doesn't change Medicare benefits. **Protect the MBI as Personally Identifiable Information (PII); it is confidential like the HICN.** Medicare Advantage and Prescription Drug plans continue to assign and use their own identifiers on their health insurance cards. For patients in these plans, continue to ask for and use the plans' health insurance cards.

Additional information

If you have questions, your MACs may have more information. Find their website at <https://go.cms.gov/MAC-website-list>.

See **MBI**, page 7

MBI from page 6

To sign up for your MAC's secure portal MBI look-up tool, visit <https://www.cms.gov/Medicare/New-Medicare-Card/Providers/MACs-Provider-Portals-by-State.pdf>.

The MBI format specifications, which provide more details on the construct of the MBI, are available at <https://www.cms.gov/Medicare/New-Medicare-Card/Understanding-the-MBI.pdf>.

Document history

Date of change	Description
March 19, 2020	We revised the article to clarify that you need the beneficiary's first name, last name, date of birth, and SSN to use MBI look-up tool. All other information remains the same.
February 12, 2020	We revised the article to add a sentence to the MBI look-up tool option for getting an MBI to show what happens if the beneficiary record has a date of death. All other information remains the same.
January 2, 2020	We reissued the article to update certain language to show the use of the MBI is fully implemented.
August 19, 2019	We reissued this article to show that all new Medicare cards have been mailed, to encourage providers to use MBIs now to protect patients' identities, to emphasize that providers must use MBIs beginning January 1, 2020, and to explain the rejection codes providers will get if they submit a HICN after January 1, 2020.
March 6, 2019	We revised this article to add language that the MBI look-up tool can be used to obtain an MBI even for patients in a Medicare Advantage Plan. All other information remains the same.

Date of change	Description
December 10, 2018	The article was revised to update the language regarding when MACs can return an MBI through the MBI look up tool (page 1). All other information remains the same.
July 11, 2018	This article was revised to provide additional information regarding the format of the MBI not using letters S, L, O, I, B, and Z (page 2).
June 25, 2018	This article was revised to provide additional information regarding the ways your staff can get MBIs (<i>Provider action needed</i> section).
June 21, 2018	The article was revised to emphasize the need to submit the MBI without hyphens or spaces to avoid rejection of your claim. All other information remains the same.
May 25, 2018	Initial article released.

MLN Matters® Number: SE18006 *Revised*
 Article Release Date: March 19, 2020
 Related CR Transmittal Number: N/A
 Related Change Request (CR) Number: N/A
 Effective Date: N/A
 Implementation N/A

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT® only copyright 2018 American Medical Association.

MSI reminder announcement: There is still time to evaluate our services!

There is still time to share your experiences about the services we provide. Please complete the MAC Satisfaction Indicator (MSI) survey. These survey results will help us gain valuable insights and determine process improvements.

https://www.surveymogizmo.com/s3/5439699/?MAC_BRNC=9&MAC=JN-First_Coast

OTPs

Revised rates for opioid treatment programs (OTPs)

The Further Consolidated Appropriations Act of 2020 (FCAA) signed December 20, 2019, revises the allowances for OTP services. This changes the allowances First Coast Service Options provided in its December 16, 2019, teleconference; a link to a PDF of that presentation may be found here: [OTP Teleconference Presentation](#).

Please use the amounts below to replace those found on page 30 of that presentation.

HCPCS	Florida Loc 99	Florida Loc 03	Florida Loc 04	Puerto Rico	U.S. Virgin Islands
G2067	206.28	214.03	221.27	208.01	208.01
G2068	257.26	265.01	272.25	258.99	258.99
G2069	1756.04	1764.08	1771.58	1757.83	1757.83
G2070	5323.98	5342.34	5359.47	5328.06	5328.05
G2071	424.33	443.56	461.51	428.60	428.60
G2072	5541.56	5569.77	5596.11	5547.83	5547.83
G2073	1341.42	1349.46	1356.96	1343.21	1343.21
G2074	160.58	167.85	174.65	162.20	162.20
G2076	178.20	186.28	193.82	180.00	180.00
G2077	109.51	114.47	119.10	110.61	110.61
G2078	35.28	35.28	35.28	35.28	35.28
G2079	86.26	86.26	86.26	86.26	86.26
G2080	30.72	32.12	33.42	31.03	31.03

Keep updated...

Use the tools and useful information found on medicare.fcso.com to stay updated on changes associated with the Medicare program.



This section of *Medicare B Connection* features summaries of new and revised local coverage determinations (LCDs) developed as a result of either local medical review or comprehensive data analysis initiatives. These initiatives are designed to ensure the appropriateness of medical care and to make sure that the Medicare administrative contractor (MAC) jurisdiction N (JN) Part A LCDs and review guidelines are consistent with accepted standards of medical practice.

Refer to our [LCDs/Medical Coverage webpage](#) for full-text LCDs, including final LCDs, draft LCDs available for comment, LCD statuses, and LCD comment/response summaries.

Effective and notice dates

Effective dates are provided in each LCD, and are based on the date services are furnished unless otherwise noted in the LCD. Medicare contractors are required to offer a 45-day notice period for LCDs; the date the LCD is posted to the website is considered the notice date.

Electronic notification

To receive quick, automatic notification when new and revised LCDs are posted to the website, subscribe to the [First Coast eNews mailing list](#). Simply enter your email address and select the subscription option that best meets your needs.

More information

For more information, or, if you do not have internet access, to obtain a hardcopy of a specific LCD, contact Medical Policy at:

Medical Policy and Procedures
PO Box 2078
Jacksonville, FL 32231-0048



Looking for LCDs?

Would you like to find local coverage determinations (LCD) in 10 seconds or less? [First Coast's LCD lookup](#) helps you find the coverage information you need quickly and easily. Just enter a procedure code, keyword, or the LCD's "L number," click the corresponding button, and the application will automatically display links to any LCDs applicable to the parameters you specified. Best of all, depending upon the speed of your internet connection, the LCD search process can be completed in less than 10 seconds.

Advance beneficiary notice

Modifier GZ must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not had** an advance beneficiary notification (ABN) signed by the beneficiary.

Note: Line items submitted with the modifier GZ will be automatically denied and will not be subject to complex medical review.

Modifier GA must be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny a service as not reasonable and necessary and they **do have** on file an ABN signed by the beneficiary.

All claims not meeting medical necessity of a local coverage determination must append the billed service with modifier GA or GZ.

Your Feedback Matters

To ensure that our website meets the needs of our provider community, we carefully analyze your feedback and implement changes to better meet your needs. Discover the results of your feedback on our "[Website enhancements](#)" page. You'll find the latest enhancements to our provider websites and find out how you can share your thoughts and ideas with First Coast's web team.

Revised LCDs/Articles

Vascular endothelial growth factor inhibitors for the treatment of ophthalmological diseases -- revision to the Part A and Part B billing and coding article

Article ID number: A56716 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on a reconsideration request, ICD-10-CM diagnosis codes E11.3551, E11.3552, E11.3553, E11.3591, E11.3592, and E11.3593 were added to the “ICD-10 Codes that Support Medical Necessity/Group 4 Codes:” section of the billing and coding article for the Food and Drug Administration (FDA) indication of diabetic retinopathy for Healthcare Common Procedure Coding System (HCPCS) code J0178.

Effective date

This billing and coding article revision is effective for claims

processed **on or after February 19, 2020**, for services rendered **on or after May 13, 2019**. LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A billing and coding article for an LCD may be found by selecting “Related Local Coverage Documents” in the “Section Navigation” drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please [click here](#).

Sacroiliac joint injection -- revision to Part B billing and coding article

Article ID number: A57539 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on the 2020 Healthcare Common Procedure Coding System (HCPCS) update, the “CPT®/HCPCS Codes/Group 1 Codes:” and “ICD 10 Codes that Support Medical Necessity/Group 1 Paragraph:” sections of the sacroiliac joint injection billing and coding article were revised to add Current Procedural Terminology (CPT®) code 64451.

Effective date

This billing and coding article revision is effective for claims

processed **on or after February 20, 2020**, for services rendered **on or after January 1, 2020**. LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A coding article for an LCD (when present) may be found by selecting “Related Local Coverage Documents” in the “Section Navigation” drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please [click here](#).

Major joint replacement (hip and knee) -- revision to the Part A and Part B billing and coding article

Article ID number: A57765 (Florida, Puerto Rico/U.S. Virgin Islands)

The billing and coding article for major joint replacement (hip and knee) was revised to add ICD-10-CM diagnosis codes T84.195A, T84.195D, and T84.195S to the “ICD-10 Codes that Support Medical Necessity/Group 1 Codes:” section.

Effective date

This billing and coding article revision is effective for claims processed **on or after February 18, 2020**, for services

rendered **on or after October 1, 2015**.

LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A billing and coding article for an LCD may be found by selecting “Related Local Coverage Documents” in the “Section Navigation” drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please [click here](#).

BRCA1 and BRCA2 genetic testing -- revision to the Part A and Part B billing and coding article

Article ID number: A57449 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on further review of the BRCA1 and BRCA2 genetic testing billing and coding article, the “CPT®/HCPCS Codes/Group 1 Codes:” and “ICD-10 Codes that Support Medical Necessity/Group 1 Paragraph:” sections of the billing and coding article were revised to remove Proprietary Laboratory Analyses (PLA) code 0134U.

Effective date

This billing and coding article revision is effective for claims

processed on or after February 17, 2020, for services rendered on or after February 8, 2020. LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A billing and coding article for an LCD may be found by selecting “Related Local Coverage Documents” in the “Section Navigation” drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please [click here](#).

Trastuzumab - trastuzumab biologics -- revision to the Part A and Part B Billing and Coding Article

Article ID number: A56660 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on the Food and Drug Administration (FDA) approval of Enhertu (fam-trastuzumab deruxtecan- nxi), Healthcare Common Procedural Coding System (HCPCS) code C9399 was added to the “CPT®/HCPCS Codes/Group 1 Paragraph:/Codes:” section of this billing and coding article for Part A and Part B. Also, HCPCS code J9999 was added to the “CPT®/HCPCS Codes/Group 2 Paragraph:/Codes:” section of this billing and coding article for Part B. In addition, HCPCS codes C9399 and J9999 were added to the “ICD-10 Codes that Support Medical Necessity/Group 1 Paragraph:” section of this billing and coding article.

Effective date

This billing and coding article revision is effective for claims processed on or after February 26, 2020, for services rendered on or after December 20, 2019.

LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A billing and coding article for an LCD may be found by selecting “Related Local Coverage Documents” in the “Section Navigation” drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please [click here](#).

Peripheral nerve blocks -- revision to Part B billing and coding article

Article ID number: A57788 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on further review of the peripheral nerve blocks billing and coding article, it was determined that Current Procedural Terminology (CPT®) code 64451 was added in error, therefore, it is being removed from the “CPT®/HCPCS Codes/Group 1 Codes:” and “ICD 10 Codes that Support Medical Necessity/Group 1 Paragraph:” sections of the billing and coding article.

Effective date

This billing and coding article revision is effective for claims

processed on or after February 20, 2020, for services rendered on or after January 1, 2020.

LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A coding article for an LCD (when present) may be found by selecting “Related Local Coverage Documents” in the “Section Navigation” drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please [click here](#).

Pegfilgrastim -- revision to the Part A and Part B local coverage determination and billing and coding article

LCD/Article ID number: L33747/A57725 (Florida, Puerto Rico/U.S. Virgin Islands)

The local coverage determination (LCD) for pegfilgrastim was revised to add the new Food and Drug Administration (FDA) approved biosimilar drug pegfilgrastim-bmez to the “Coverage Indications, Limitations, and/or Medical Necessity” section of the LCD under “History/ Background and/or General Information”, “Covered Indications” and “Limitations”.

In addition, the “Sources of Information” section of the LCD was updated. Also, the billing and coding article was revised to add the new FDA approved biosimilar drug Ziextenzo™ (pegfilgrastim-bmez) (Healthcare Common Procedure Coding System [HCPCS] codes C9399/J3590) to the “CPT®/HCPCS Codes/Group 1 Paragraph:” and “ICD-10 Codes that Support Medical Necessity/Group 1

Paragraph:” sections.

Effective date

This billing and coding article revision is effective for claims processed **on or after February 26, 2020**, for services rendered **on or after November 4, 2019**.

LCDs are available through the CMS Medicare coverage database at:

<https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A billing and coding article for an LCD may be found by selecting “Related Local Coverage Documents” in the “Section Navigation” drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please [click here](#).

Stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) – revision to the Part A and Part B local coverage determination and billing and coding article

LCD/Article ID number: L33410/A57275 (Florida, Puerto Rico/U.S. Virgin Islands)

The intention of this stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) local coverage determination (LCD) revision is to update the coverage guidelines based on more current data and literature.

This LCD recognizes two distinct treatment approaches and is specific to treatment delivery: stereotactic radiosurgery (SRS) and stereotactic body radiation therapy (SBRT) are noninvasive means of administering high-dose radiotherapy to discreet tumor foci in cranial or extracranial locations respectively.

Also, the related billing and coding article (A57275)

addresses coding guidelines in support of the reasonable and necessary services as outlined in the LCD.

Effective date

This billing and coding article revision is effective for claims processed **on or after April 19, 2020**. LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A coding article for an LCD may be found by selecting “Related Local Coverage Documents” in the “Section Navigation” drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please [click here](#).

Revision to the Part A and Part B Billing and Coding Article A57077

Article ID number: A57077 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on review of the controlled substance monitoring and drugs of abuse testing billing and coding article, the “CPT®/HCPCS Codes/Group 1 Codes:” and “ICD-10 Codes that Support Medical Necessity/Group 1 Paragraph:” sections of the billing and coding article were revised to remove Current Procedural Terminology (CPT®) code 83789 as it is not a test for drugs.

Effective date

This billing and coding article revision is effective for

claims processed **on or after March 6, 2020**, for services rendered **on or after January 1, 2016**.

LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A billing and coding article for an LCD may be found by selecting “Related Local Coverage Documents” in the “Section Navigation” drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please [click here](#).

Revision to the Part A and Part B billing and coding article A57778

Article ID number: A57778 (Florida, Puerto Rico/U.S. Virgin Islands)

Based on a review, this billing and coding article was revised to add the new Food and Drug Administration (FDA) approved drug Panzyga® (immune globulin intravenous, human – IFAS) (Healthcare Common Procedure Coding System [HCPCS] codes C9399/J1599) to the “CPT®/HCPCS Codes/Group 1 Paragraph:/Group 1 Codes:” and “ICD-10 Codes that Support Medical Necessity/Group 1 Paragraph:” sections.

Effective date

This billing and coding article revision is effective for

claims processed **on or after March 16, 2020**, for services rendered **on or after August 2, 2018**.

LCDs are available through the CMS Medicare coverage database at

<https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A billing and coding article for an LCD may be found by selecting “Related Local Coverage Documents” in the “Section Navigation” drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please [click here](#).

Revision to the Part A and Part B article A52571

Article ID number: A52571 (Florida, Puerto Rico/U.S. Virgin Islands)

The Centers for Medicare & Medicaid Services (CMS) provide instructions to contractors regarding Medicare payment for drugs and biologicals incident to a physician’s service.

The instructions also provide contractors with a process for determining if an injectable drug is usually self-administered and therefore not covered by Medicare. Guidelines for the evaluation of drugs for the list of excluded self-administered injectable drugs incident to a physician’s service are in the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 15, Section 50.2.

The following drugs have been added to the Medicare administrative contractor (MAC) Jurisdiction N (JN) self-administered drug (SAD) list: Tremfya® (guselkumab) (J1628) and Stelara® (ustekinumab) subcutaneous (J3357).

This article revision is effective for services rendered **on or after May 3, 2020**.

The evaluation of drugs for addition to the SAD list is an on-going process. Providers are responsible for monitoring the SAD list for the addition or deletion of drugs.

The First Coast Service Options, Inc. (First Coast) SAD list is available at: <https://medicare.fcso.com/Self-administered-drugs>.

Retired LCDs/Articles

Multiple Part B LCDs being retired

LCD and Article ID numbers: L33903/A57673, L33914/A57507, L33917/A57508, L33918/A57521, L33965/A56759 (Florida/Puerto Rico/U.S. Virgin Islands)

Based on review of the following local coverage determinations (LCDs) and billing and coding articles, it was determined that they are no longer required and therefore, are being retired.

L33903/A57673 – Diagnostic Laryngoscopy

L33914/A57507 – Iridotomy by Laser Surgery

L33917/A57508 – Laser Trabeculoplasty

L33918/A57521 – Laser Treatment for Psoriasis

L33965/A56759 – Urinary Tumor Markers for Bladder Cancer

Effective date

The retirement of these LCDs and billing and coding articles is effective for services rendered **on or after March 11, 2020**.

LCDs are available through the CMS Medicare coverage database at <https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx>.

A billing and coding article for an LCD (when present) may be found by selecting “Related Local Coverage Documents” in the “Section Navigation” drop-down menu at the top of the LCD page.

Note: To review active, future and retired LCDs, please [click here](#).

Upcoming provider outreach and educational events

Evaluation and management (E/M): Hospital services - are you coding correctly?

Date: April 30

Time: 10 - 11:30 p.m. ET

Type of Event: Webcast

View our complete calendar of events

Note: Unless otherwise indicated, designated times for educational events are stated as ET, and the focus is to Florida, Puerto Rico, and the U.S. Virgin Islands.

Two easy ways to register

Online – Visit our provider training website at [First Coast University](#), log on to your account and select the course you wish to register. Class materials are available under “My Courses” no later than one day before the event.

First-time User? Set up an account by completing [Create User Account Form](#) online. Providers who do not have yet a national provider identifier may enter “99999” in the NPI field. You will receive logon information within 72 hours of your request.

Fax – Providers without internet access may request a fax registration form through our Registration Hotline at 1-904-791-8103. Class materials will be faxed to you the day of the event.

Please Note:

- Pre-registration is required for all teleconferences, webcasts and in-person educational seminars.
- Dates and times are subject to change prior to opening of event registration.

Registrant's Name: _____

Registrant's Title: _____

Provider's Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Provider Address: _____

City, State, ZIP Code: _____

Keep checking our [website](#) for details and newly scheduled educational events (teleconferences, webcasts, etc.).

Never miss a training opportunity

If you or your colleagues were unable to attend one of our past Medicare educational webcasts, you still have the opportunity to learn about the topics covered during the training session. Visit the First Coast Medicare training website, download the recording of the event, and listen to the webcast when you have the time.

Take advantage of 24-hour access to free online training

In addition to live training events, we also offer you the advantage of self-paced, free online courses that will allow you and your staff to train when and where it is most convenient for you. In addition, our comprehensive course catalog allows you to find the Medicare training that fits your specific needs, and several of our online courses offer CEUs. Learn more on the First Coast Medicare training website and explore our catalog of online courses.



The Centers for Medicare & Medicaid Services (CMS) *MLN Connects*[®] is an official *Medicare Learning Network*[®] (MLN) – branded product that contains a week’s worth of news for Medicare fee-for-service (FFS) providers. CMS sends these messages weekly to national health industry provider associations, who then disseminates the *MLN Connects*[®] to its membership as appropriate.

MLN Connects[®] for February 20, 2020

MLN Connects[®] for February 20, 2020

[View this edition as a PDF](#)

News

- CMS Develops New Code for Coronavirus Lab Test
- CMS Program Statistics: 2018 Data
- Medicare Diabetes Prevention Program: Become a Medicare Enrolled Supplier

Compliance

- Bill Correctly for Medicare Telehealth Services

Events

- Dementia Care: CMS Toolkits Call — March 3
- Part A Providers: QIC Appeals Demonstration Call — March 5
- Ground Ambulance Organizations: Data Collection for Public Safety-Based Organizations Call — March 12
- Open Payments: Your Role in Health Care Transparency Call — March 19

MLN Matters[®] Articles

- The Role of Therapy under the Home Health Patient-Driven Groupings Model (PDGM)
- Second Update to CR 11152 Implementation of the Skilled Nursing Facility (SNF) Patient Driven Payment Model (PDPM)
- New Medicare Beneficiary Identifier (MBI) Get It, Use It — Revised
- What New Home Health Agencies (HHAs) Need to Know about Being Placed in a Provisional Period of Enhanced Oversight — Revised
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) - April 2020 Update — Revised

Publications

- Administrative Simplification: EFT and ERA Transactions

Medicare Learning Network[®], MLN Connects[®] and MLN Matters[®] are registered trademarks of the U.S. Department of Health and Human Services (HHS).

Hands-on internet-based PECOS training by appointment

Join First Coast Service Options, in Jacksonville, for a free, interactive session on using Internet-based PECOS to electronically create or update your Medicare enrollment. Make your appointment today!



MLN Connects® for February 27, 2020

MLN Connects® for February 27, 2020

[View this edition as a PDF](#) 

News

- Quality Payment Program: MIPS 2019 Data Submission Period Open through March 31
- Anesthesia Modifiers: Comparative Billing Report in March

Compliance

- Inpatient Rehabilitation Facility Services: Follow Medicare Billing Requirements

Claims, Pricers & Codes

- COVID-19: New ICD-10-CM Code and Interim Coding Guidance
- SNF PDPM Claims Issue
- FQHC: Mass Adjustment of Claims

Events

- Dementia Care: CMS Toolkits Call -- March 3
- Part A Providers: QIC Appeals Demonstration Call -- March 5

- Ground Ambulance Organizations: Data Collection for Public Safety-Based Organizations Call -- March 12
- Open Payments: Your Role in Health Care Transparency Call -- March 19

MLN Matters® Articles

- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update
- Implementation of the Long Term Care Hospital (LTCH) Discharge Payment Percentage (DPP) Payment Adjustment
- Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging- Approval of Using the K3 Segment for Institutional Claims -- Revised
- Accepting Payment from Patients with a Medicare Set-Aside Arrangement -- Revised
- January 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.0 -- Revised

Publications

- Medicare Quarterly Provider Compliance Newsletter, Volume 10, Issue 2
- Quality Payment Program: 2020 Resources

Medicare Learning Network®, MLN Connects® and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

MLN Connects® Special Edition for March 4, 2020

CMS Announces Actions to Address Spread of Coronavirus

CMS calls on all health care providers to activate infection control practices and issues guidance to inspectors as they inspect facilities affected by Coronavirus

On March 4, the Centers for Medicare & Medicaid Services (CMS) announced several actions aimed at limiting the spread of the Novel Coronavirus 2019 (COVID-19). Specifically, CMS is issuing a call to action to health care providers across the country to ensure they are implementing their infection control procedures, which they are required to maintain at all times. Additionally, CMS is announcing that, effective immediately and, until further notice, State Survey Agencies and Accrediting Organizations will focus their facility inspections exclusively on issues related to infection control and other serious health and safety threats, like allegations of abuse – beginning with nursing homes and hospitals. Critically, this shift in approach, first announced yesterday by Vice President Pence, will allow inspectors to focus their energies on addressing the spread of COVID-19.

As the agency responsible for Medicare and Medicaid, CMS requires facilities to maintain infection control and prevention policies as a condition for participation in the programs. CMS is also issuing three memoranda to State Survey Agencies, State Survey Agency directors and Accrediting Organizations – to inspect thousands of Medicare-participating health care providers across the country, including nursing homes and hospitals.

“Today’s actions, taken together, represent a call to action across the health care system,” said CMS Administrator Seema Verma. “All health care providers must immediately review their procedures to ensure compliance with CMS’ infection control requirements, as well as the guidelines from the Centers for Disease Control and Prevention (CDC). We sincerely appreciate the proactive efforts of the nursing home and hospital associations that have already galvanized to provide up-to-the-minute information to their members. We must continue working together to keep American patients and residents safe and healthy and prevent the spread of COVID-19.”

The first memorandum provides important detail with

See **MLN**, page 17

MLN from page 16

respect to the temporary focus of surveys on infection control and other emergent issues. Importantly, it notes that, in addition to the focused inspections, statutorily-required inspections will also continue in the 15,000 nursing homes across the country using the approximately 8,200 state survey agency surveyors. Surveys will be conducted according to the following regime:

- All immediate jeopardy complaints (a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment or death or harm) and allegations of abuse and neglect;
- Complaints alleging infection control concerns, including facilities with potential COVID-19 or other respiratory illnesses;
- Statutorily required recertification surveys (Nursing Home, Home Health, Hospice, and ICF/IID facilities);
- Any re-visits necessary to resolve current enforcement actions;
- Initial certifications;
- Surveys of facilities/hospitals that have a history of infection control deficiencies at the immediate jeopardy level in the last three years;
- Surveys of facilities/hospitals/dialysis centers that have a history of infection control deficiencies at lower levels than immediate jeopardy

The memorandum also includes protocols for the inspection process in situations in which COVID-19 is identified or suspected. These protocols include working closely with CMS regional offices, coordinating with CDC, and other relevant agencies at all levels of government. The agency is also providing key guidance related to inspectors' usage of adequate personal protective equipment.

The other two memoranda provide critical answers to

common questions that nursing homes and hospitals may have with respect to addressing cases of COVID-19.

For example, the memoranda discuss concerns like screening staff and visitors with questions about recent travel to countries with known cases and the severity of infection that would warrant hospitalization instead of self-isolation. They detail the process for transferring patients between nursing homes and hospitals in cases for which COVID-19 is suspected or diagnosed. They also describe the circumstances under which providers should take precautionary measures (like isolation and mask wearing) for patients and residents diagnosed with COVID-19, or showing signs and symptoms of COVID-19.

Finally, the agency is announcing that it has deployed an infection prevention specialist to CDC's Atlanta headquarters to assist with real-time in guidance development.

These actions from CMS are focused on protecting American patients and residents by ensuring health care facilities have up-to-date information to adequately respond to COVID-19 concerns while also making it clear to providers that as always, CMS will hold them accountable for effective infection control standards. The agency is also supplying inspectors with necessary and timely information to safely and accurately inspect facilities.

To view each memo, please visit:

- [Suspension of Survey Activities](#)
- [Guidance for Infection Control and Prevention Concerning Coronavirus Disease \(COVID-19\): FAQs and Considerations for Patient Triage, Placement and Hospital Discharge](#)
- [Guidance for Infection Control and Prevention of Coronavirus Disease 2019 \(COVID-19\) in nursing homes](#)

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

Where do I find...

Looking for something specific and don't know where to find it? Find out how to perform routine tasks or locate information that visitors frequently visit our site to accomplish or find. Check out the "Where do I find" page.



MLN Connects® for March 5, 2020

MLN Connects® for March 5, 2020

[View this edition as a PDF](#) 

News

- DMEPOS Suppliers: HCPCS Codes Affected by Further Consolidated Appropriations Act
- Medicare Promoting Interoperability Program: CAH Reconsideration Forms due March 6
- Medicare Promoting Interoperability Program: Submit Proposals for New Measures by July 1
- PEPPERS for Short-term Acute Care Hospitals
- 2018 Geographic Variation Public Use File
- Help Your Patients Make Informed Food Choices

Compliance

- Ambulance Fee Schedule and Medicare Transports

Claims, Pricers & Codes

- Average Sales Price Files: April 2020

Events

- Ground Ambulance Organizations: Data Collection for Public Safety-Based Organizations Call — March 12
- Open Payments: Your Role in Health Care Transparency Call — March 19
- Anesthesia Modifiers: Comparative Billing Report Webinar — March 19
- Ground Ambulance Organizations: Data Collection for Medicare Providers Call — April 2

- LTCH and IRF Quality Reporting Programs: SPADEs In-Depth Training Event — June 9-10

MLN Matters® Articles

- Standard Elements for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Order, and Master List of DMEPOS Items Potentially Subject to a Face-to-Face Encounter and Written Orders Prior to Delivery and, or Prior Authorization Requirements
- Remittance Advice Remark Code (RARC), Claims Adjustment Reason Code (CARC), Medicare Remit Easy Print (MREP) and PC Print Update
- Quarterly Update for the Temporary Gap Period of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (CBP) - April 2020
- International Classification of Diseases, 10th Revision (ICD-10) and Other Coding Revisions to National Coverage Determination (NCDs) — July 2020 Update

Publications

- Administrative Simplification: Claim Status Basics
- Hospice Quality Reporting Program: Timeliness Compliance Threshold for HIS Submissions
- Guide to Reducing Chronic Kidney Disease Disparities in the Primary Care Setting

Multimedia

- Ambulance Services Call: Audio Recording and Transcript

Medicare Learning Network®, MLN Connects® and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

MLN Connects® Special Edition for March 6, 2020

CMS Develops Additional Code for Coronavirus Lab Tests

Agency Issues Fact Sheets Detailing Coverage under Programs

On March 6, CMS took additional actions to ensure America's patients, healthcare facilities and clinical laboratories are prepared to respond to the 2019-Novel Coronavirus (COVID-19).

CMS has developed a second Healthcare Common Procedure Coding System (HCPCS) code that can be used by laboratories to bill for certain COVID-19 diagnostic

tests to help increase testing and track new cases. In addition, CMS released new fact sheets that explain Medicare, Medicaid, Children's Health Insurance Program, and Individual and Small Group Market Private Insurance coverage for services to help patients prepare as well.

"CMS continues to leverage every tool at our disposal in responding to COVID-19," said CMS Administrator Seema Verma. "Our new code will help encourage doctors and laboratories to use these essential tests for patients who need them. At the same time, we are providing critical information to our 130 million beneficiaries, many of whom are understandably wondering what will be covered when

See **MLN**, page 19

MLN from page 18

it comes to this virus. CMS will continue to devote every available resource to this effort, as we cooperate with other government agencies to keep the American people safe.”

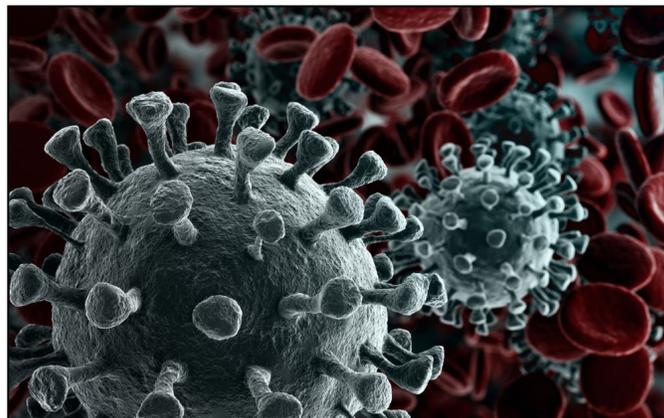
HCPCS is a standardized coding system that Medicare and other health insurers use to submit claims for services provided to patients. Last month, CMS developed the first HCPCS code (U0001) to bill for tests and track new cases of the virus. This code is used specifically for CDC testing laboratories to test patients for SARS-CoV-2. The second HCPCS billing code (U0002) allows laboratories to bill for non-CDC laboratory tests for SARS-CoV-2/2019-nCoV (COVID-19). On February 29, 2020, the Food and Drug Administration (FDA) issued a new, streamlined policy for certain laboratories to develop their own validated COVID-19 diagnostics. This second HCPCS code may be used for tests developed by these additional laboratories when submitting claims to Medicare or health insurers. CMS expects that having specific codes for these tests will encourage testing and improve tracking.

The Medicare claims processing systems will be able to accept these codes starting on April 1, 2020, for dates of service on or after February 4, 2020. Local Medicare Administrative Contractors (MACs) are responsible for developing the payment amount for claims they receive for these newly created HCPCS codes in their respective jurisdictions until Medicare establishes national payment rates. Laboratories may seek guidance from their MAC on payment for these tests prior to billing for them. As with other laboratory tests, there is generally no beneficiary cost sharing under Original Medicare.

To ensure the public has clear information on coverage and benefits under CMS programs, the agency also released three fact sheets that cover diagnostic laboratory tests, immunizations and vaccines, telemedicine, drugs, and cost-sharing policies.

Medicare Fact Sheet Highlights: In addition to the diagnostic tests described above, Medicare covers all medically necessary hospitalizations, as well as brief “virtual check-ins,” which allows patients and their doctors to connect by phone or video chat.

Medicaid and Children’s Health Insurance Program (CHIP) Fact Sheet Highlights: Testing and diagnostic services are commonly covered services, and laboratory and x-ray services are a mandatory benefit covered and reimbursed in all states. States are required to provide both inpatient and outpatient hospital services to beneficiaries. All



states provide coverage of hospital care for children and pregnant women enrolled in CHIP. Specific questions on covered benefits should be directed to the respective state Medicaid and CHIP agency.

Individual and Small Group Market Insurance Coverage: Existing federal rules governing health insurance coverage, including with respect to viral infections, apply to the diagnosis and treatment of with Coronavirus (COVID-19). This includes plans purchased through HealthCare.gov. Patients should contact their insurer to determine specific benefits and coverage policies. Benefit and coverage details may vary by state and by plan. States may choose to work with plans and issuers to determine the coverage and cost-sharing parameters for COVID-19 related diagnoses, treatments, equipment, telehealth and home health services, and other related costs.

Summary of CMS Public Health Action on COVID-19 to date:

On March 4, 2020, CMS issued a call to action to healthcare providers nationwide to ensure they are implementing longstanding infection control procedures and issued important guidance to help State Survey Agencies and Accrediting Organizations prioritize their inspections of healthcare facilities to focus exclusively on issues related to infection control

and other serious health and safety threats. For more information on CMS actions to prepare for and respond to COVID-19, visit: [CMS Announces Actions to Address Spread of Coronavirus](#).

On February 13, 2020, CMS issued a new HCPCS code for healthcare providers and laboratories to test patients for COVID-19 using the CDC-developed test. For more information about this code: [Public Health News Alert: CMS Develops New Code for Coronavirus Lab Test](#).

On February 6, 2020, CMS issued a [memo](#) to help the nation’s healthcare facilities take critical steps to prepare for COVID19.

On February 6, 2020, CMS also gave CLIA-certified laboratories information about how they can test for SARS-CoV-2. Read more: [Suspension of Survey Activities memorandum](#)

For the updated information on the range of CMS activities to address COVID-19, visit the [Current Emergencies](#) webpage.

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

MLN Connects® Special Edition for March 9, 2020

COVID-19 Response: CMS Issues FAQs to Assist Medicare Providers

On March 6, CMS issued *frequently asked questions and answers (FAQs)* for health care providers regarding Medicare payment for laboratory tests and other services related to the 2019-Novel Coronavirus (COVID-19).

The agency is receiving questions from providers and created this document to be transparent and share answers to some of the most common questions.

Included in the FAQs is:

- Guidance on how to bill and receive payment for testing patients at risk of COVID-19.
- Details of Medicare's payment policies for laboratory and diagnostic services, drugs, and vaccines under Medicare Part B, ambulance services, and other medical services delivered by physicians, hospitals, and facilities accepting government resources.
- Information on billing for telehealth or in-home provider services. Since 2019, the Trump Administration has expanded flexibilities for CMS to pay providers for virtual check-ins and other digital communications with patients, which will make it easier for sick patients to stay home and lower the risk of spreading the infection.

This FAQ, and earlier CMS actions in response to the COVID-19 virus are part of the ongoing White House Task Force efforts.

To keep up with the important work CMS is doing in response to COVID-19, visit the [Current Emergencies](#) website.

Below is an updated list of CMS' actions to date:

- **March 5:** Issued a second Healthcare Common Procedure Coding System (HCPCS) code for



certain COVID-19 laboratory tests, in addition to three fact sheets about coverage and benefits for medical services related to COVID-19 for CMS programs

- **March 4:** Issued a call to action to health care providers nationwide and offered important guidance to help State Survey Agencies and Accrediting Organizations prioritize their inspections of healthcare
- **February 13:** Issued a new HCPCS code for providers and laboratories to test patients for COVID-19
- **February 6:** Gave CLIA-certified laboratories information about how they can test for SARS-CoV-2
- **February 6:** Issued a memo to help the nation's health care facilities take critical steps to prepare for COVID-19

The Medicare Learning Network®, MLN Connects®, and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

Medicare Learning Network®

The Medicare Learning Network® (MLN) is the home for education, information, and resources for the health care professional community. The MLN provides access to CMS Program information you need, when you need it, so you can focus more on providing care to your patients. Find out what the MLN has to offer you and your staff at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo>

MLN Connects® for March 12, 2020

MLN Connects® for March 12, 2020

[View this edition as a PDF](#) 

News

- CMS Sends More Detailed Guidance to Providers about COVID-19
- HHS Finalizes Historic Rules to Provide Patients More Control of Their Health Data
- Quality Payment Program: MIPS 2019 Data Submission Deadline March 31
- Hospital Quality Reporting: Comment on Draft QRDA I Implementation Guide by April 1
- Inclusion of Lower Limb Prosthetics in DMEPOS Prior Authorization
- Clean Hands Count: Prevent and Control Infections
- March is National Colorectal Cancer Awareness Month

Compliance

- Incorrect Billing of HCPCS L8679 - Implantable Neurostimulator, Pulse Generator, Any Type

Events

- Open Payments: Your Role in Health Care Transparency Call — March 19
- Medicare Promoting Interoperability Program Call for Measures Webinar — March 19
- Ground Ambulance Organizations: Data Collection for

Medicare Providers Call — April 2

- Interoperability and Patient Access Final Rule Call — April 7
- LTCH and IRF Quality Reporting Programs: SPADEs Webinar — April 14

MLN Matters® Articles

- NCD 20.4 Implantable Cardiac Defibrillators (ICDs)
- Section 1876 and 1833 Cost Plan Enrollee Access to Care through Original Medicare
- April 2020 Integrated Outpatient Code Editor (I/OCE) Specifications Version 21.1
- Proper Use of Modifier 59 — Revised
- Quarterly Update to the Medicare Physician Fee Schedule Database (MPFSDB) - April 2020 Update — Revised

Publications

- Evacuating and Receiving Patients in the Midst of a Wildfire
- Administrative Simplification: Eligibility and Benefits Transaction Basics

Multimedia

- Dementia Care Call: Audio Recording and Transcript

Medicare Learning Network®, MLN Connects® and MLN Matters® are registered trademarks of the U.S. Department of Health and Human Services (HHS).

Take the time to 'chat' with the website team

You now have the opportunity to save your valuable time by asking your website-related questions online – with First Coast's new Live Chat service.



Phone numbers

Provider Contact Center

866-454-9007
877-660-1759 (speech and hearing impaired)

Electronic data interchange (EDI)

888-670-0940

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

888-845-8614
877-660-1759 (TTY)
FAX: 904-361-0737

The SPOT help desk

855-416-4199
FCSOSPOTHelp@FCSO.com

Addresses

Claims

Medicare Part B Claims
P.O. Box 2525
Jacksonville, FL 32231-0019

Redeterminations

Medicare Part B Redetermination
P.O. Box 2360
Jacksonville, FL 32231-0018

Redetermination of overpayments

Overpayment Redetermination, Review Request
P.O. Box 45248
Jacksonville, FL 32232-5248

Reconsiderations

C2C Innovative Solutions, Inc.
Part B QIC South Operations
ATTN: Administration Manager
PO Box 45300
Jacksonville, FL 32232-5300

General inquiries

General inquiry request
P.O. Box 2360
Jacksonville, FL 32231-0018

[>> EDOC-CS-FLINQB@fcsso.com](mailto:EDOC-CS-FLINQB@fcsso.com)
Online form

Provider enrollment

Provider Enrollment
P.O. Box 3409
Mechanicsburg, PA 17055-1849

Special or overnight deliveries

Provider Enrollment
2020 Technology Parkway Suite 100
Mechanicsburg, PA 17055-1849

Medical policy

Medical Policy and Procedure
P.O. Box 2078
Jacksonville, FL 32231-0048
medical.policy@fcsso.com

Medicare secondary payer

Medicare Part B Secondary Payer Dept.
P.O. Box 44078
Jacksonville, FL 32231-4078

Electronic data interchange (EDI)

Medicare EDI
P.O. Box 44071
Jacksonville, FL 32231-4071

Overpayments

Medicare Part B Debt Recovery
P.O. Box 44141
Jacksonville, FL 32231-4141

Medicare Education and Outreach

FAX: 904-361-0407
elarning@fcsso.com

Fraud and abuse

Fraud and abuse complaints
P.O. Box 45087
Jacksonville, FL 32232-5087

Freedom of Information Act requests

FOIA Florida
P.O. Box 2078
Jacksonville, FL 32231-2078

Overnight mail and/or special courier service

First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Websites

Provider

[First Coast Service Options Inc. \(First Coast\)](#), your CMS-contracted Medicare administrative contractor
Find your *other contractors* (e.g. DME, HHA, etc)

[Centers for Medicare & Medicaid Services](#)

E-learning Center
[First Coast University](#)

Beneficiaries

[Centers for Medicare & Medicaid Services](#)
medicare.gov

Phone numbers

Provider Contact Center

866-454-9007
877-660-1759 (speech and hearing impaired)

Electronic data interchange (EDI)

888-670-0940

Fax number (for general inquiries)

904-361-0696

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

888-845-8614
877-660-1759 (TTY)
FAX: 904-361-0737

The SPOT help desk

855-416-4199
FCSOSPOTHelp@FCSO.com

Addresses

Claims

Medicare Part B Claims
P.O. Box 45098
Jacksonville, FL 32232-5098

Redeterminations

Medicare Part B Redetermination
P.O. Box 45024
Jacksonville, FL 32232-5024

Redetermination of overpayments

First Coast Service Options Inc.
P.O. Box 45091
Jacksonville, FL 32232-5091

Reconsiderations

C2C Innovative Solutions, Inc.
Part B QIC South Operations
ATTN: Administration Manager
PO Box 45300
Jacksonville, FL 32232-5300

General inquiries

First Coast Service Options Inc.
P.O. Box 45098
Jacksonville, FL 32232-5098
[>> EDOC-CS-FLINQB@fcso.com](mailto:EDOC-CS-FLINQB@fcso.com)
[Online form](#)

Provider enrollment

CMS-855 Applications

P. O. Box 3409
Mechanicsburg, PA 17055-1849

Special or overnight deliveries

Provider Enrollment
2020 Technology Parkway Suite 100
Mechanicsburg, PA 17055-1849

Medical policy

Medical Policy and Procedure
P.O. Box 2078
Jacksonville, FL 32231-0048
medical.policy@fcso.com

Medicare secondary payer

Medicare Part B Secondary Payer Dept.
P.O. Box 44078
Jacksonville, FL 32231-4078

Electronic data interchange (EDI)

Medicare EDI, 4C
P.O. Box 44071
Jacksonville, FL 32231-4071

Overpayments

Medicare Part B Debt Recovery
P.O. Box 45013
Jacksonville, FL 32232-5013

Medicare Education and Outreach

FAX: 904-361-0407
elearning@fcso.com

Fraud and abuse

Fraud and abuse complaints
P.O. Box 45087
Jacksonville, FL 32232-5087

Freedom of Information Act requests

FOIA USVI
P.O. Box 45073
Jacksonville, FL 32231-5073

Special courier service

First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Websites

Provider

First Coast Service Options Inc. (First Coast), your CMS-contracted Medicare administrative contractor
Find your *other contractors* (e.g. DME, HHA, etc)

Centers for Medicare & Medicaid Services

E-learning Center
First Coast University

Beneficiaries

Centers for Medicare & Medicaid Services
medicare.gov

Phone numbers

Provider Contact Center

1-877-715-1921
1-888-216-8261 (speech and hearing impaired)

Electronic data interchange (EDI)

888-875-9779

Interactive voice response (IVR) system

877-847-4992

Provider enrollment

888-845-8614
877-660-1759 (TTY)
FAX: 904-361-0737

The SPOT help desk

855-416-4199
FCSOSPOTHelp@FCSO.com

Addresses

Claims

Medicare Part B Claims
P.O. Box 45036
Jacksonville, FL 32232-5036

Redeterminations

Medicare Part B Redetermination
P.O. Box 45056
Jacksonville, FL 32232-5056

Redetermination of overpayments

First Coast Service Options Inc.
P.O. Box 45015
Jacksonville, FL 32232-5015

Reconsiderations

C2C Innovative Solutions, Inc.
Part B QIC South Operations
ATTN: Administration Manager
PO Box 45300
Jacksonville, FL 32232-5300

General inquiries

First Coast Service Options Inc.
P.O. Box 45036
Jacksonville, FL 32232-5036

EDOC-CS-PRINQB@fcso.com
[Online form](#)

Provider enrollment

CMS-855 Applications

P. O. Box 3409
Mechanicsburg, PA 17055-1849

Special or overnight deliveries

Provider Enrollment
2020 Technology Parkway Suite 100
Mechanicsburg, PA 17055-1849

Medical policy

Medical Policy and Procedure
P.O. Box 2078
Jacksonville, FL 32231-0048
medical.policy@fcso.com

Medicare secondary payer

Medicare Part B Secondary Payer Dept.
P.O. Box 44078
Jacksonville, FL 32231-4078

Electronic data interchange (EDI)

Medicare EDI
P.O. Box 44071
Jacksonville, FL 32231-4071

Overpayments

Medicare Part B Debt Recovery
P.O. Box 45040
Jacksonville, FL 32231-5040

Medicare Education and Outreach

FAX: 904-361-0407
elarning@fcso.com

Fraud and abuse

Fraud and abuse complaints
P.O. Box 45087
Jacksonville, FL 32232-5087

Freedom of Information Act requests

FOIA Puerto Rico
P.O. Box 45092
Jacksonville, FL 32232-5092,

Special courier service

First Coast Service Options Inc.
532 Riverside Avenue
Jacksonville, FL 32202-4914

Websites

Provider

First Coast Service Options Inc. (First Coast), your CMS-contracted Medicare administrative contractor

Find your *other contractors* (e.g. DME, HHA, etc)

[Centers for Medicare & Medicaid Services](#)

E-learning Center
[First Coast University](#)

Beneficiaries

Centers for Medicare & Medicaid Services
medicare.gov

Order form for Medicare Part B materials

The following materials are available for purchase. To order these items, please complete and **submit this form along with your check/money order** payable to First Coast Service Options Inc. account # (use appropriate account number). Do not fax your order; it must be mailed.

Note: Payment for fee schedules cannot be combined with payment for other items; separate payments are required for purchases of items from different accounts.

Item	Acct Number	Cost per item	Quantity	Total cost
Part B subscription – The Medicare Part B jurisdiction N publications, are available free of charge online in <i>English</i> or <i>Spanish</i> . Nonprovider entities or providers who need additional copies may purchase an annual subscription. This subscription includes all issues published from October 2019 through September 2020.	40300260	\$33		
2020 fee schedule – The Medicare Part B Physician and Nonphysician Practitioner Fee Schedules, effective for services rendered January 1 through December 31, 2020, are available free of charge online in <i>English</i> or <i>Spanish</i> . Additional copies are available for purchase. The fee schedules contain payment rates for all localities. These items do not include the payment rates for injectable drugs, clinical lab services, mammography screening, or DMEPOS items. Note: Requests for hard copy paper disclosures will be completed as soon as CMS provides the direction to do so. Revisions to fees may occur; these revisions will be published in future editions of the Medicare Part B publication.	40300270	\$12		
Language preference: English [] Español []				
<i>Please write legibly</i>			Subtotal	\$
			Tax (<i>add % for your area</i>)	\$
			Total	\$

Mail this form with payment to:
First Coast Service Options Inc.
Medicare Publications
P.O. Box 406443
Atlanta, GA 30384-6443

Contact Name: _____

Provider/Office Name: _____

Phone: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

(Checks made to "purchase orders" not accepted; all orders must be prepaid)



Medicare B Connection

First Coast Service Options Inc.
P.O. Box 2078 Jacksonville, FL. 32231-0048

Attention Billing Manager